Changing Practice/Changing Lives

Update on Diabetes Prevention & Treatment

DMICC
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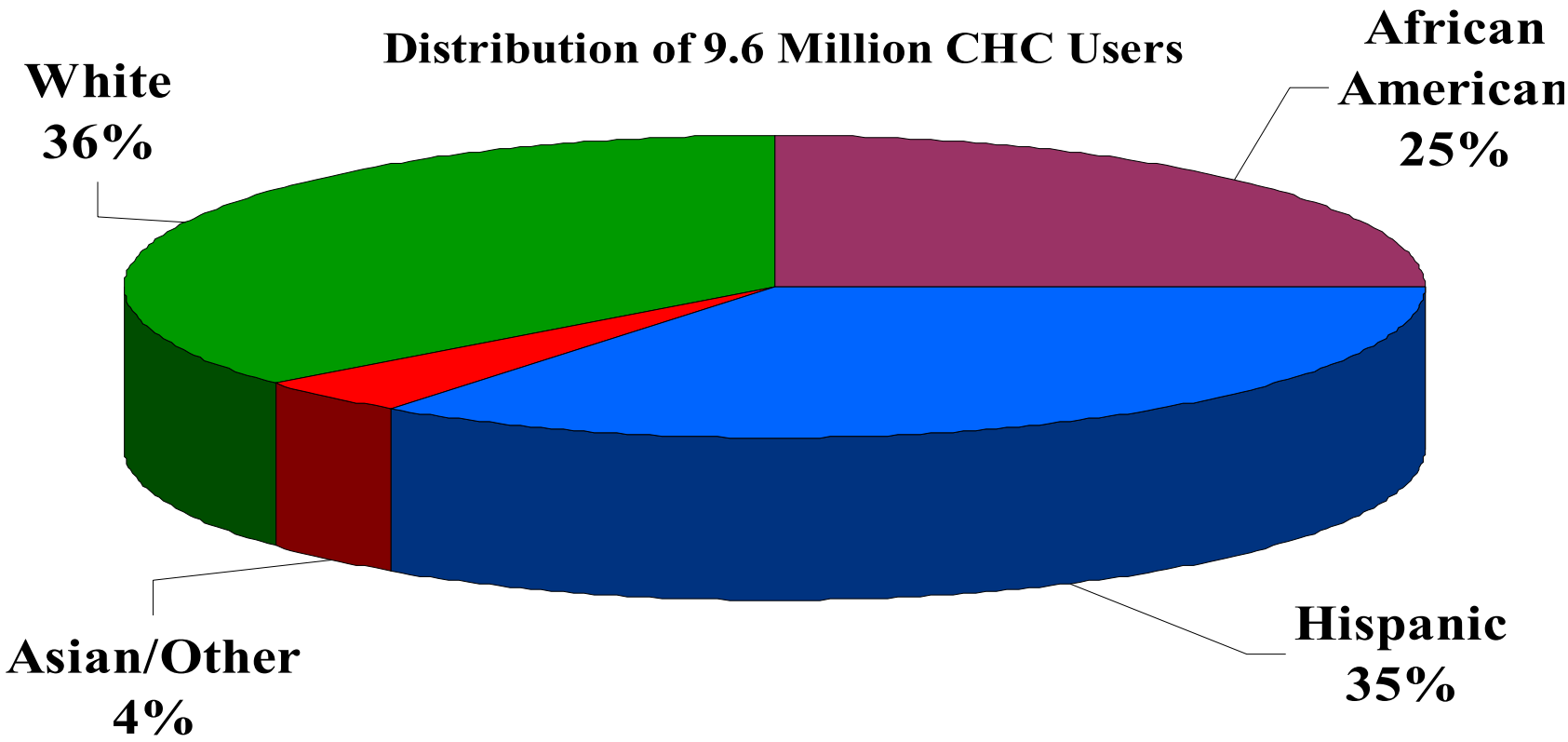
David M. Stevens, MD
HRSA/BPHC

Health Centers

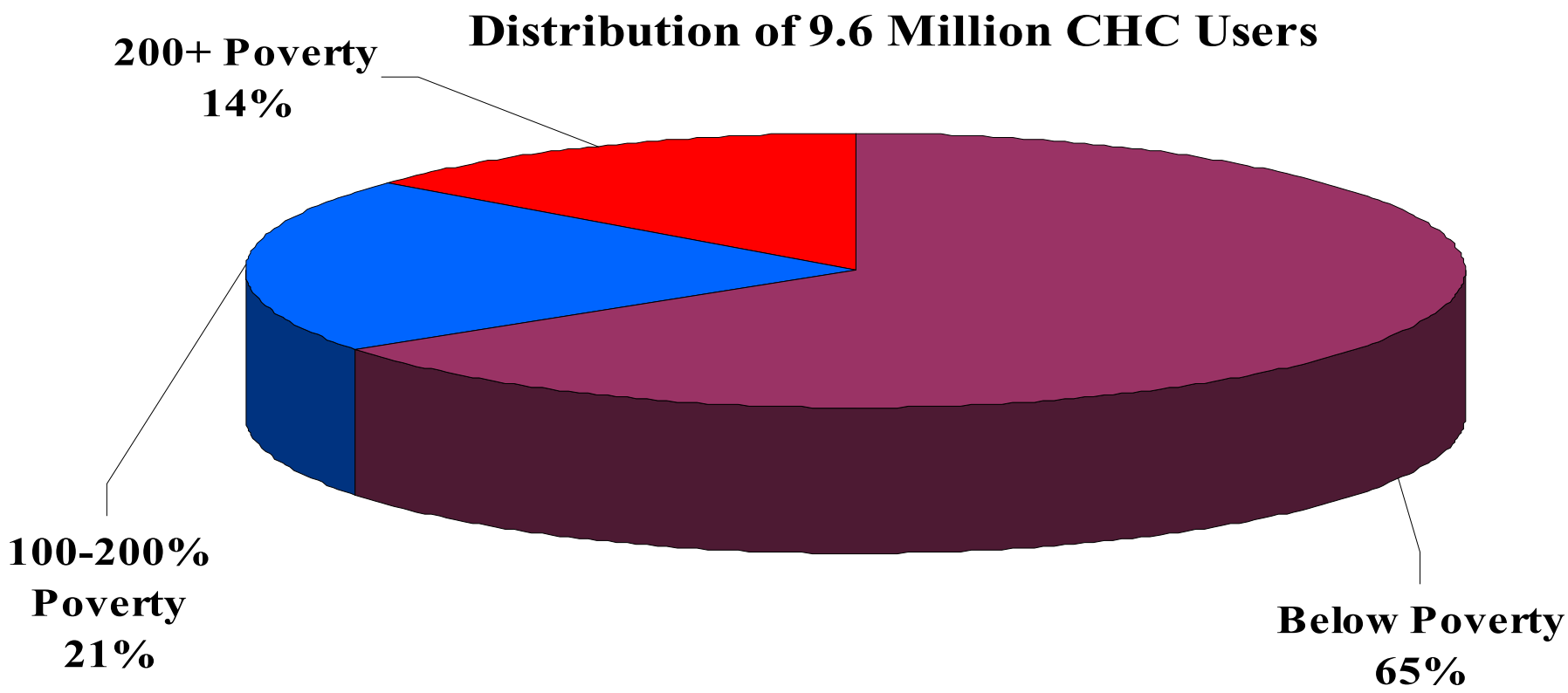
- Community controlled
- Comprehensive Primary Care
- 768 organizations
- 3,552 sites: rural & urban

UDS Answers Priority Questions: Number and Sociodemographic Characteristics of Users



Source: Uniform Data System (UDS)
Contact:NCAMPBELL@SHRS.GOV

86% Of Those Served by Health Centers Are Low Income



Source: Uniform Data System (UDS)
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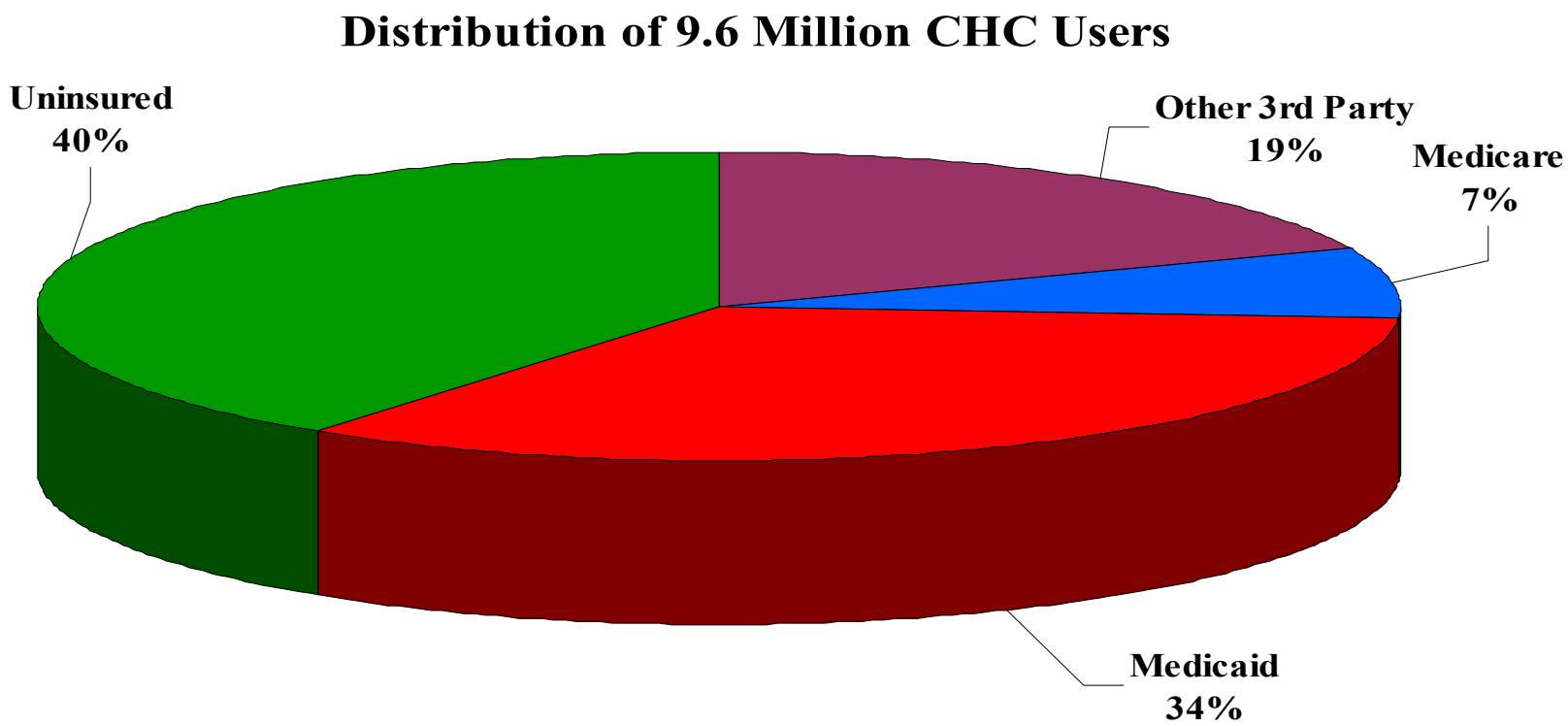
40% Of Those Served by Health Centers Are Uninsured



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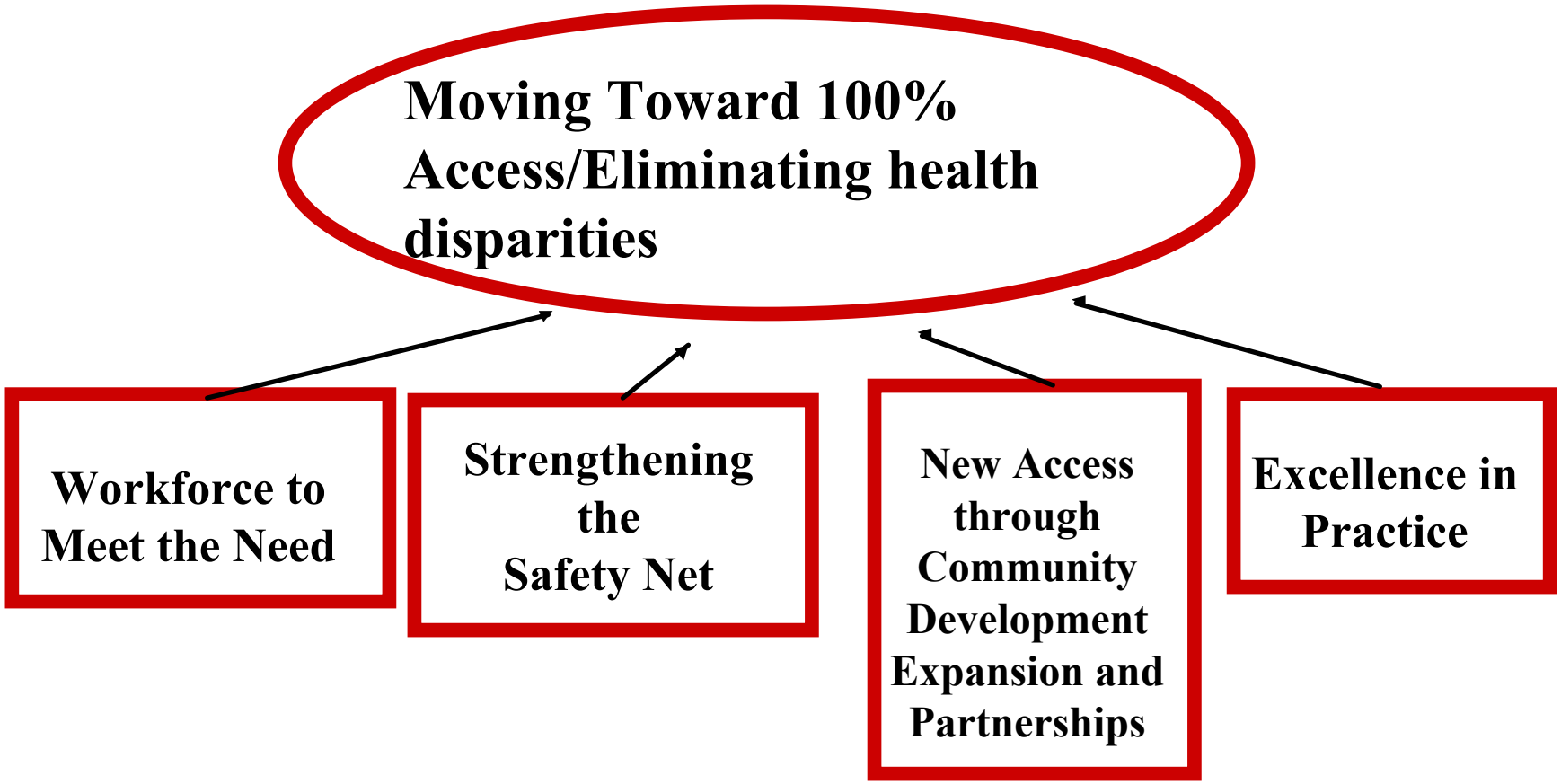
BPHC Strategic Goal and Objectives



Excellence in Practice: Strategy

- Leadership
- Transform clinical practice through models of care, improvement & learning
- Infrastructure/Support System
- Strategic Partnerships

Transform practice: Models

- **Chronic Care Model**: a population based model that relies on knowing which patients need the care, assuring that they receive knowledge-based care and actively aiding them to participate in their own care
- **Improvement Model**: A model that reaches high levels of performance by applying knowledge through rapid testing, transforms the care by changing systems, and expands the change throughout the practice.
- **Learning Model:** A performance-based learning method that supports a community of learners to apply, adapt, share, and generate knowledge, and spread positive change.

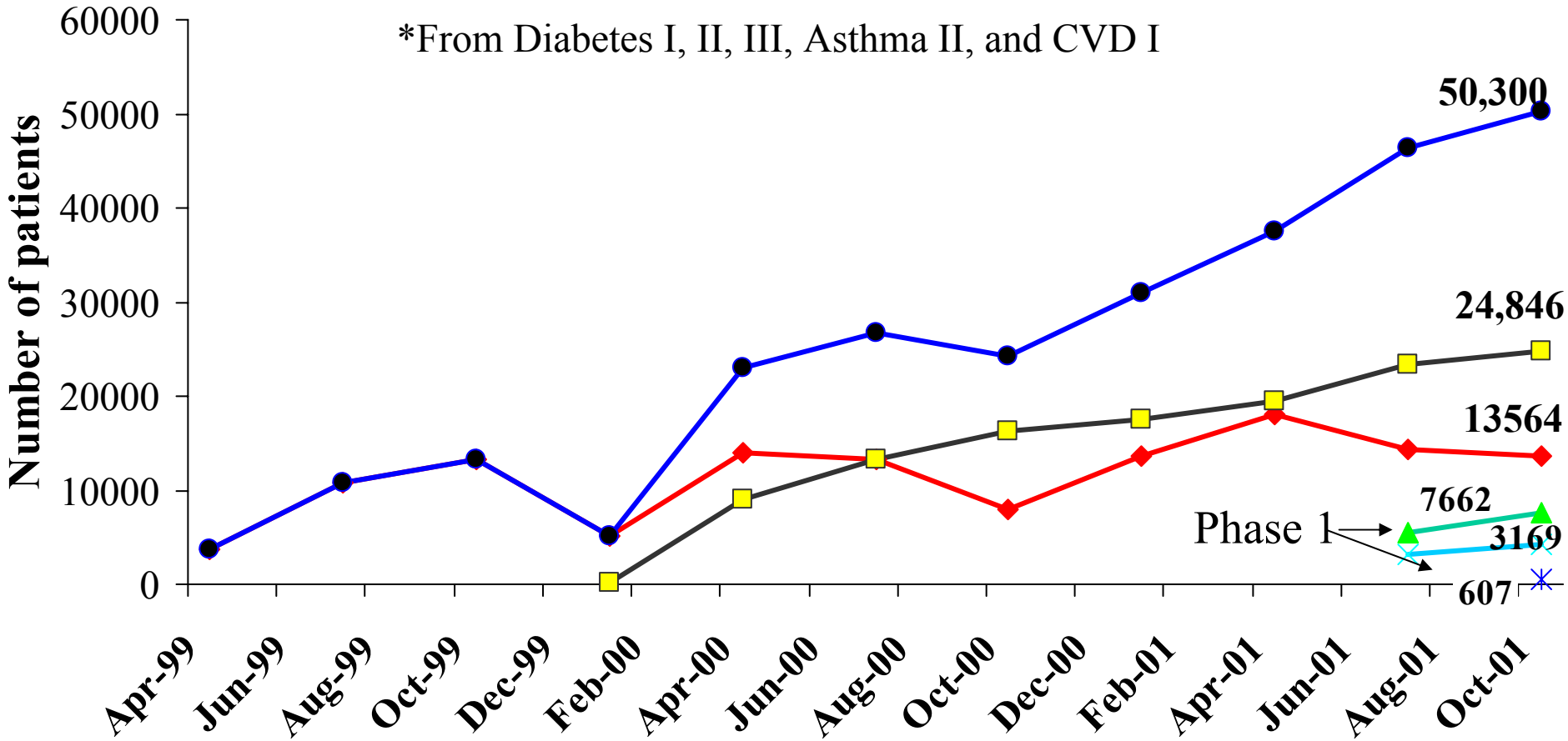
ICIC, Robert Wood Johnson Foundation at the McCall Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound

Diabetes Collaborative Measures

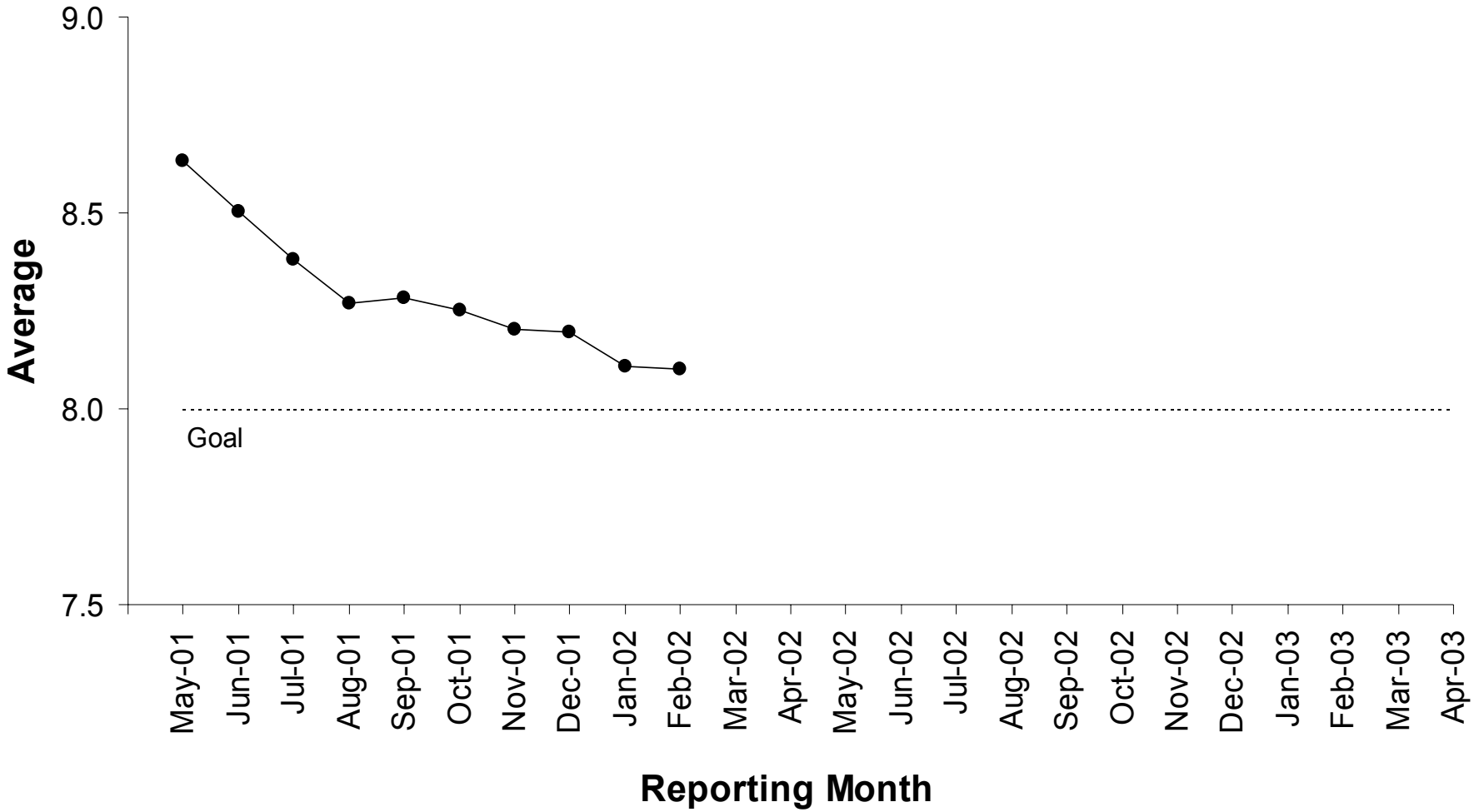
- *Documented Patient self-management goal
- *Glycemic control
- Prevention of cardiac complications
- Prevention of vascular complications
- Immunization
- Oral Health
- Depression screening
- *Registry size & practice sites(270 health centers focused on diabetes)

Number of Health Center Patients* in Clinical Mgt. Information Systems 1999-2001

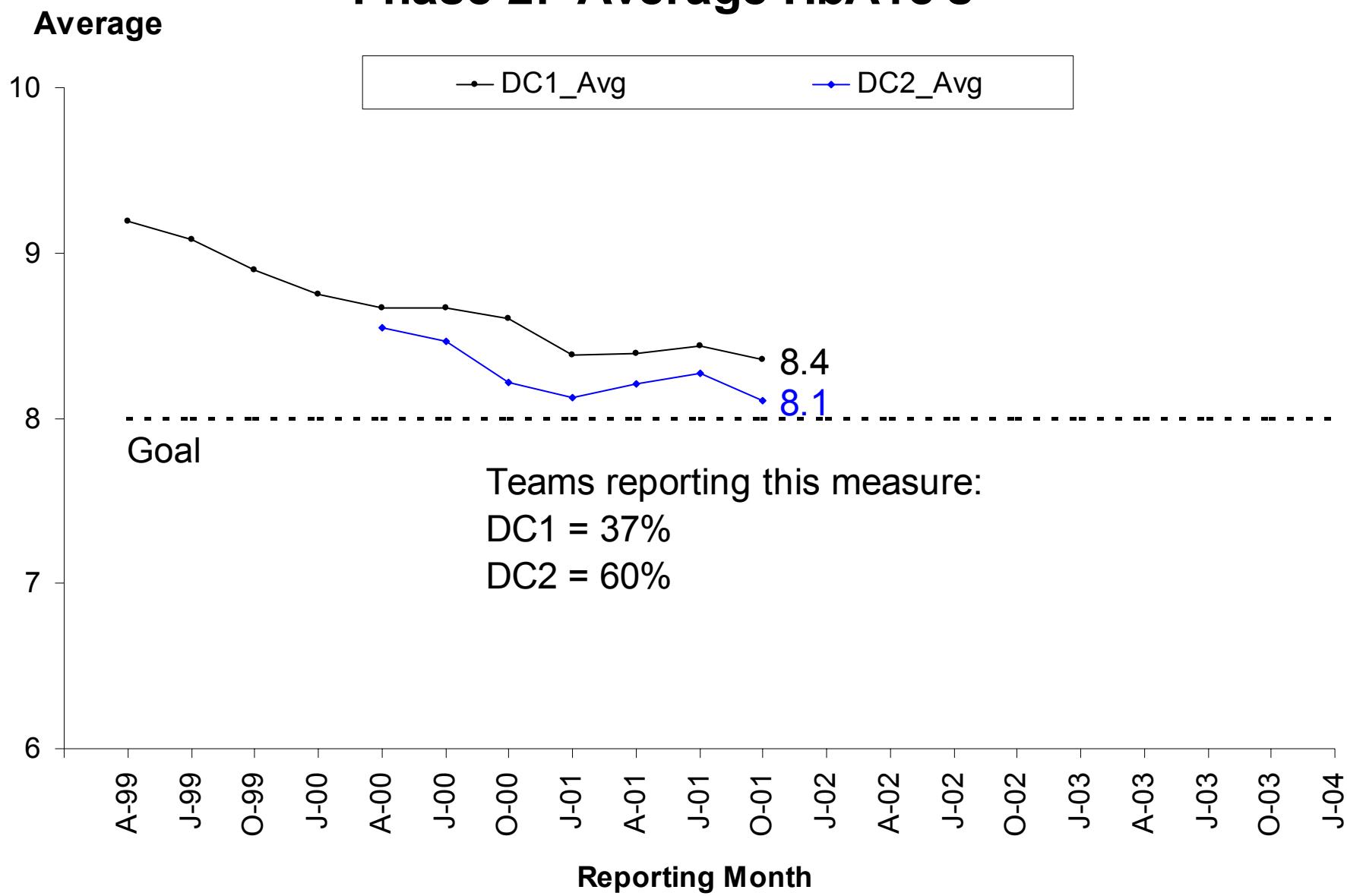
*From Diabetes I, II, III, Asthma II, and CVD I



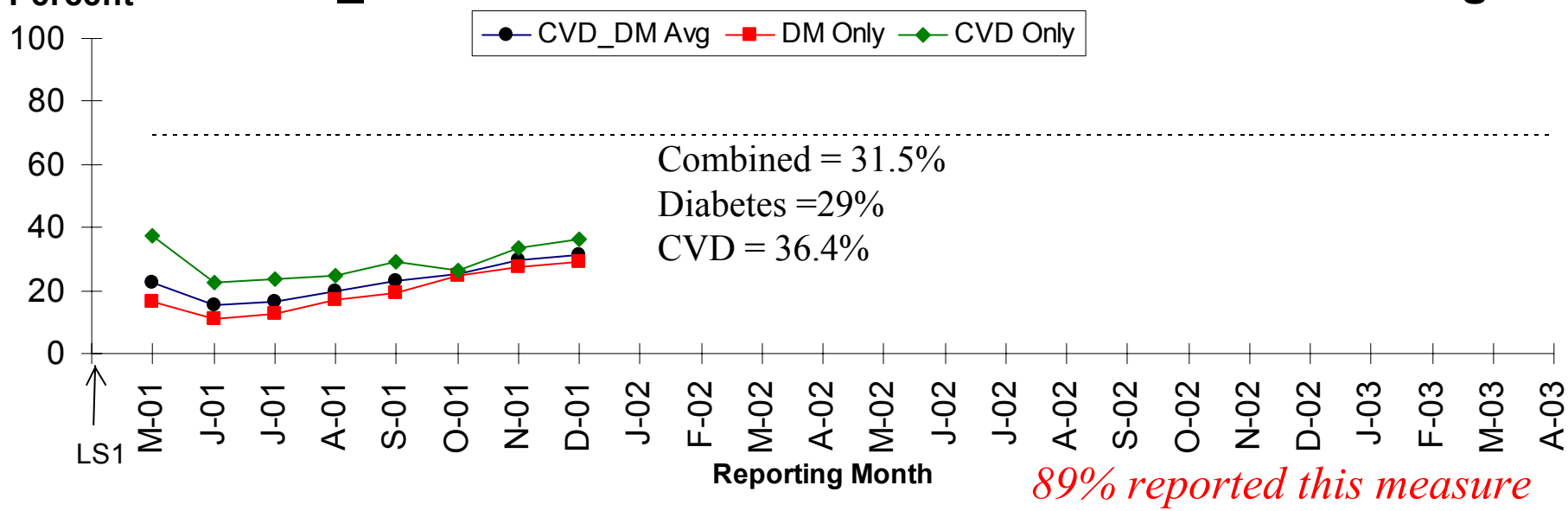
Diabetes Collaborative 3 - National Report
Average HbA1c's



Phase 2: Average HbA1c's

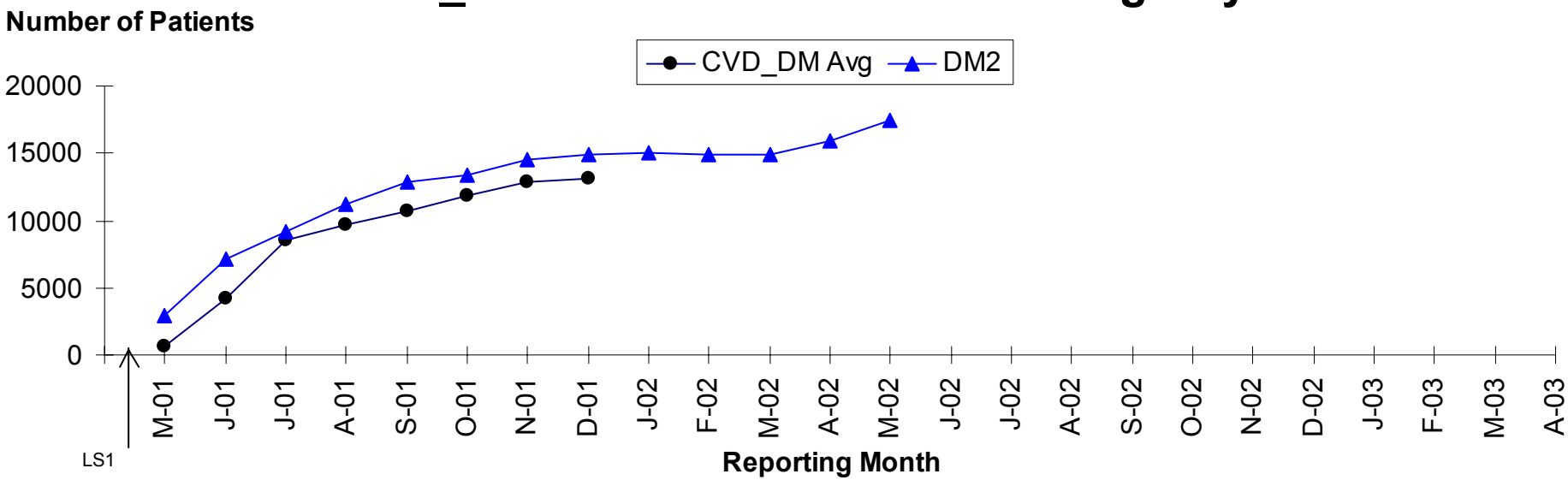


CVD_DM3 Collaborative - Percent with SM Goal Setting

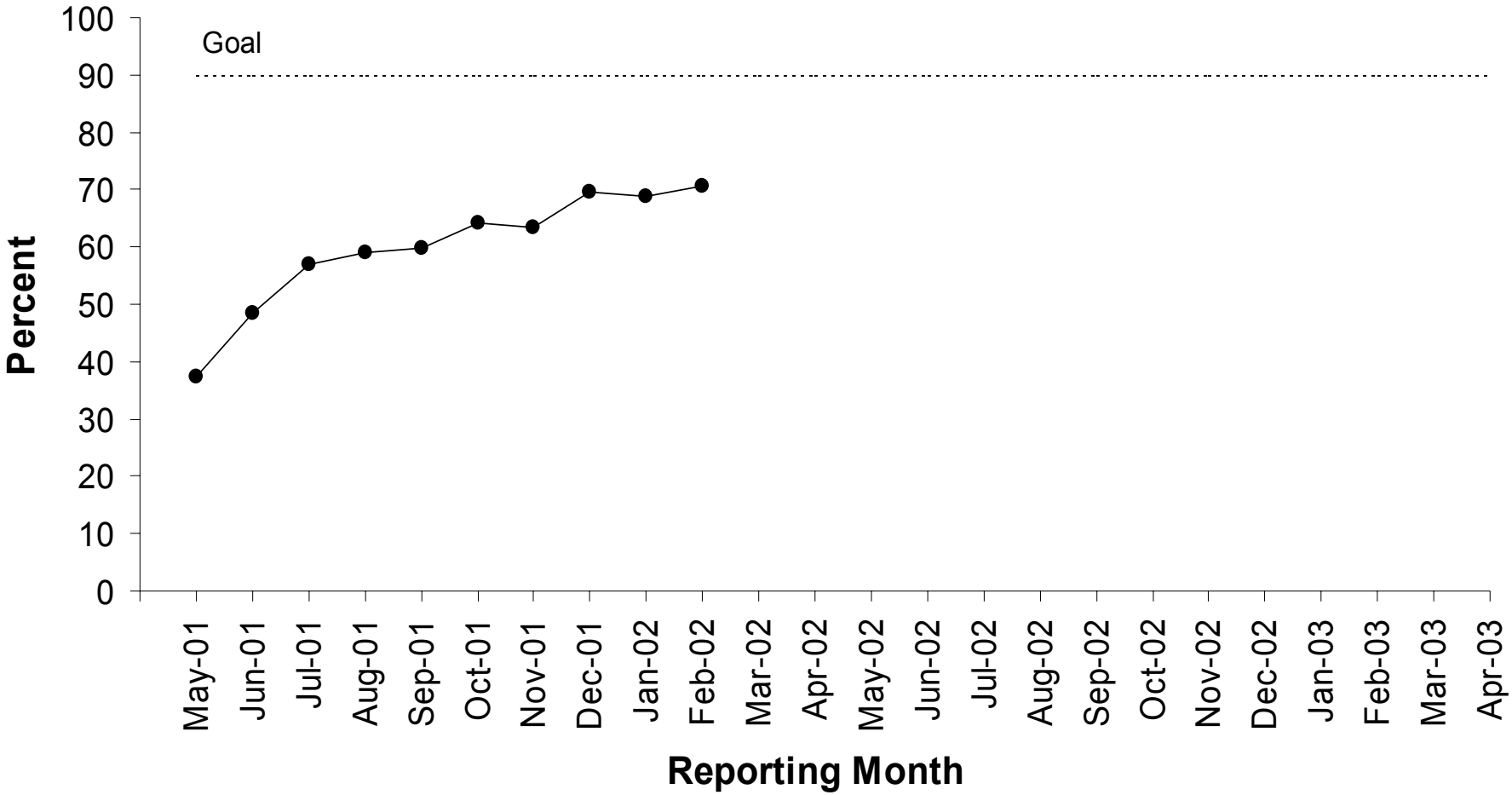


89% reported this measure

CVD_DM3 Collaborative - Total Registry Size

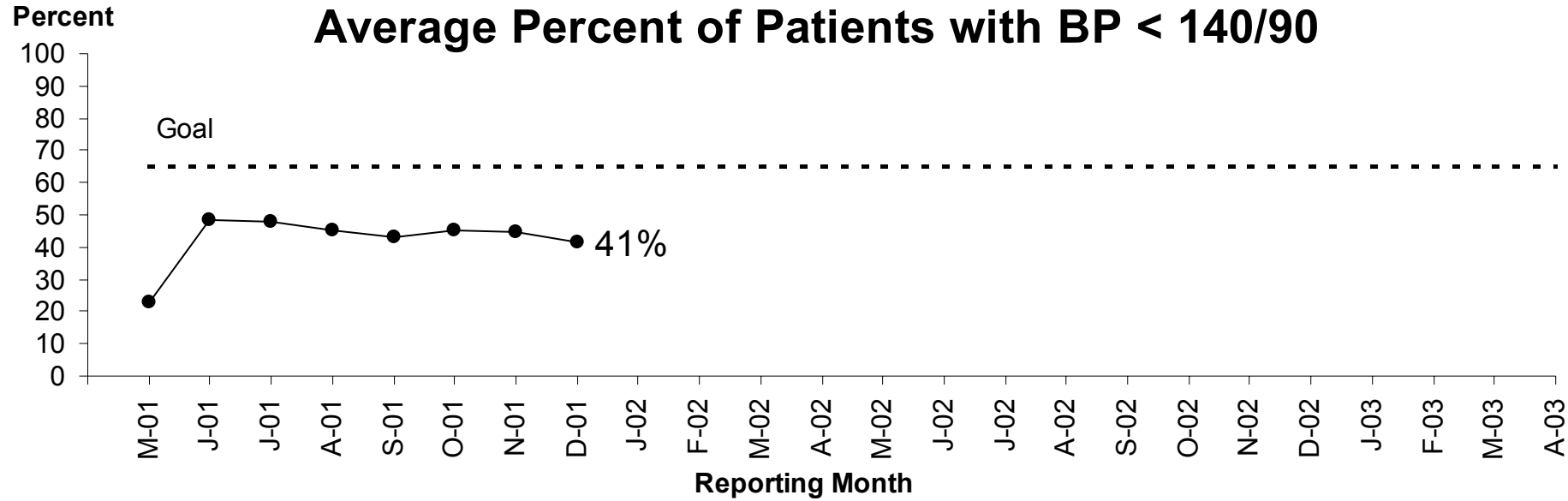


CVD Collaborative 1 - National Report
Average Percent of Patients with Two BP's in Last 12 Months

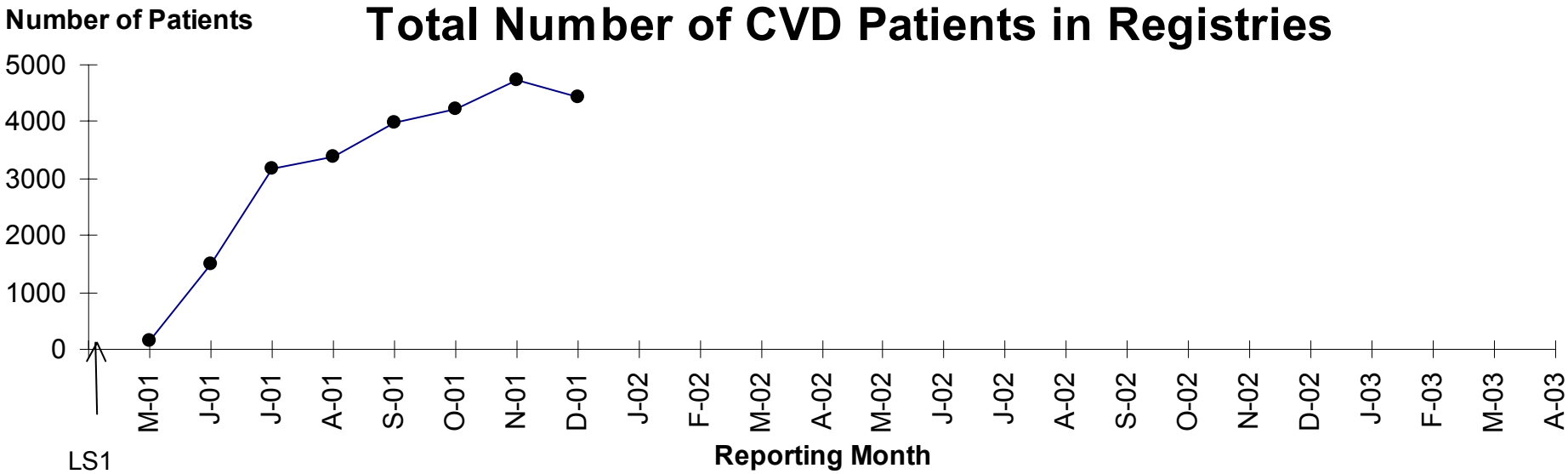


CVD Collaborative 1

Average Percent of Patients with BP < 140/90



Total Number of CVD Patients in Registries



88% of teams reported both measures

Partnership Outcomes

- CDC lead for expert panel for both diabetes & cardiovascular disease collaboratives
- 60 Health Center Diabetes Control partnerships
  - 22 new
  - 38 expanded
- Trained over 40 state Diabetes Control Programs
- Collaboration with American Diabetes Association, Bayer Corp.

Prevention & Chronic Disease Management

Beyond Diabetes: Collaboration to Improve Health & Access

- ***Current:***
  - **DM/Cardiovascular: CDC/SAMSHA, IHI**
  - **Asthma II: EPA/CDC, IHI**
  - **HIV: HIV/AIDS Bureau**
  - **Depression II: SAMHSA, IHI**
- ***In Development*:**
  - **Cancer: NIH(NCI), ICIC, CDC, IHI**
  - **Prevention: NCI, CDC, MCHB, IHI**

Diabetes Prevention Pilot: CDC & HRSA Partnership

- **Develop concepts and measures for translating recommendations into primary care for the underserved, using care model**
- **Incorporate in both diabetes collaborative and future prevention collaborative**
- **Time frame: begin pilot 3rd quarter 02 and continue for 9-12 months as part of development of prevention collaborative**